



Thank you for choosing our office for your Dental needs.  
The Notice of Privacy Practices Form is your copy to keep. However please bring the Medical forms, Office Policy, and Consent for use and disclosure of health information form with you to your dental appointment.

For directions, you may visit our web site at

**[www.smilesonmain.com](http://www.smilesonmain.com)**

and

proceed to the Our Office menu option where you may print directions to either of our offices.

Contact Information

Smiles On Main  
342 North Main Street, Suite 110  
Alpharetta, GA 30009

678-762-1613

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_ have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
(Please Print Name)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

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**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_

## OFFICE POLICY

Payment in full is expected at the time services are rendered unless other arrangements are made in advance. For your convenience, we do accept the following:

Visa, MasterCard, Discover, & American Express

A wide variety of services are available in this office; therefore, we have no uniform policy that covers all procedures and treatments. An insurance policy is a contract between the insured and the insurance company. However, we will assist you by filing your Primary insurance as a courtesy for you. You will need to pay your deductible and co-payment on the services rendered. You will be responsible for filing your secondary insurance if you have any. The receipt that we will give you will assist you in filing secondary insurance.

Time is valuable for both you and us. If a confirmed appointment is broken, there will be a \$50.00 broken appointment fee. Every effort to assist you in making a convenient appointment has been made; if you must cancel please notify us 48 hours PRIOR to your scheduled appointment. If an appointment has been scheduled, please be on time, since ample time has been set for your treatment. If you are TEN minutes late, your appointment may be rescheduled.

Minors under the age of 18 with scheduled appointments must be accompanied by a parent or legal guardian.

A finance charge will be added to all accounts 30 days past due. A service charge for RETURNED checks will be added to the account in the amount of \$50.00 for each occurrence. Any outstanding account balance 90 days or older with no activity will be turned over to a collection agency or Magistrate court. It will be your responsibility to pay for any and all collection fees or court costs.

Any outstanding account not covered by your insurance company will be your responsibility.

If you have any questions we will be glad to answer them for you. We will be glad to arrange a financial arrangement if necessary prior to initiation of treatment.

THANK YOU,

By signature, I have read and understand the office policy of this practice. In cases where payments are being accepted directly from the insurance company, I authorize payment to the provider.

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date